

## Exhibit G - Health Home Tiers for Billing

The Washington Health Home program has designated three tiers that define the level of care coordination services provided:

1. Initial engagement and Health Action Plan. (HAP) completion = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically the Tier will not change from month to month, between Tier Two and Tier Three, but does change when the client and/or their caregivers consistently demonstrate an *intensive* or *low* level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home services include;

- **Comprehensive Care Management:** The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.

Examples:

- Conduct outreach and engagement activities
  - Develop the HAP setting client centered goals and action steps to achieve the goals
  - Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
  - Prepare crisis intervention and resiliency plans
  - Support the client to live in the setting of their choice
  - Identify possible gaps in services and secure needed supports
- **Care Coordination and Health Promotion:** Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.

Examples:

- Support to implement the HAP
- Encourage and monitor progress towards individualized short and long term goals
- Coordinate with service providers, case managers, and health plans
- Conduct or participate in interdisciplinary teams
- Assist and support the client with scheduling health appointments and accompany if needed
- Communicate and consult with all providers and the client
- Provide individualized educational materials according to the needs and goals of the client

- Promote participation in community educational and support groups
- **Comprehensive Transitional Care:** The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.  
Examples:
  - Follow-up with hospitals/ED upon notification of admission or discharge
  - Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
  - Assist with access to needed services or equipment and ensure it is received
  - Provide education to the client and providers that are located at the setting from which the person is transitioning
  - Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
  - Ensure follow-up with Primary Care Provider (PCP)
  - Review and verify medication reconciliation post discharge is completed
- **Individual and Family Supports:** Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.  
Examples:
  - Provide education and support of self-advocacy including referral to Peer Support specialists
  - Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
  - Educate client, family or caregivers of advance directives, client rights, and health care issues
  - Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation level, literacy and cultural preferences
- **Referral to Community and Social Supports:** The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.  
Examples:
  - Identify, refer and facilitate access to relevant community and social services that support the client's HAP
  - Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
  - Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services
- **Use of Health Information Technology to link services:** Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

The descriptions below of each Tier Level are to be used as a guide when selecting the Health Home Tier.

### **Tier One – Outreach, Engagement and Health Action Plan (HAP) Development**

- Lead Entity assigns an eligible client to a Care Coordination Organizations (CCO) using PRISM information or other data systems to match the client to the CCO which will provide the Health Homes services and outreach begins.

- a. The CCO assigns the client to a Care Coordinator who completes a preliminary assessment of the client's Health Home needs, based upon known health and other risk factors.
  - b. Contact is made with the client to arrange a face-to-face meeting to confirm the client's desire to participate in the Health Home Program.
  - c. Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop the HAP.
  - d. The client's Health Action Plan shall provide evidence of:
    1. Chronic conditions, severity factors and gaps in care, the client's activation level, and opportunities for potentially avoidable emergency department visits, inpatient hospitalizations and institutional placement;
    2. Client self-identified goals, needed interventions or action steps, transitional care planning, supports and interventions; and
    3. Use of self-management, recovery and resiliency principles using person-identified supports, including family members, and paid and non-paid caregivers.
- Once the client agrees to participate in the Health Home program and the HAP is developed, a Tier One claim using procedure code G9148 may be submitted for payment. The Tier One payment will only be paid once in a client's lifetime to a lead entity for each enrolled and engaged client.

### **Tier Two - Intensive Health Home Care Coordination**

- Intensive Health Home care coordination is the highest level of care coordination. This level of care coordination includes evidence that the Care Coordinator, the client and the client's caregivers are actively engaged in the HAP, participating in activities that are in support of improved health and well-being, have value for the client and caregivers, and support an active level of care coordination through delivery of the Health Home services. At a minimum, Tier Two includes one face-to-face visit between the client and the care coordinator during the month in which qualifying health home services are provided.
  - **Exceptions** can be approved to the monthly care coordinator's face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client's HAP goals and included in the action steps may be considered as an exception.
  - **Exceptions** can be approved to monthly care coordinator's face-to-face visit by the Health Home Lead entity as long as there is evidence of other types of qualifying health home activities being provided.
- Document health home services provided in the client's health record. Examples of services may include:
  - a. Administration and follow up on clinical, functional, and resource use screenings, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual.
  - b. Continuity and coordination of care services through in-person visits, telephone calls and team meetings, and the ability to accompany clients to health care provider appointments, as needed.
  - c. Client assessments to determine readiness for self-management and promotion of self-management skills so the client is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning.

- d. Fostering communication between the client and providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health, chemical dependency, developmental disability and long-term services and supports.
  - e. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP.
  - f. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.
  - g. Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs to increase the client's knowledge about their health care conditions and improve adherence to prescribed treatment.
- At least one of the six qualifying Health Home services must be provided during the month prior to submitting a Tier Two claim using procedure code G9149 for payment.

### **Tier Three – Low Level Health Home Care Coordination**

- Tier Three is selected when one of the situations described below matches the care coordination needs of the client. Typically after the Tier One activity of establishing the HAP is completed a client will move to the Tier Two level. In some cases, based on the preference of the client, and their individual needs, they may move directly from Tier One to Tier Three. For example, a client with an Activation Level of Four (4) who is actively self-directing their care and needs infrequent coaching to maintain their health.
- The Health Home Tier system was not designed to have clients changing Tiers month to month based solely on the number or types of contacts. The movement to a Tier or between Tiers is based on:
  - a. Engagement of the client and/or their caregivers;
  - b. Activity within the HAP;
  - c. Provision of at least one of the six qualifying Health Home services; and
  - d. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).
- The following situations describe when Tier Three (Low Level Care Coordination) would apply for a client.
  - a. Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.
  - b. The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.
  - c. The client and the Care Coordinator identify that the client has achieved a sustainable level of self-management for their primary chronic conditions.
  - d. Activity level supports a high level of activation and client demonstrates optimal self-management and health promotion skills.
- At Tier Three the review of the HAP must occur at least every four months reviewing progress towards goals, level of activation, and new or unidentified care opportunities.
- At least one of the six qualifying Health Home service must be provided prior to submitting a Tier Three claim with procedure code G9150 for payment.

## **Client Movement Between Tiers**

- Based on the needs and preferences of the client they may move between Tiers Two and Three; higher intensity to lower or lower intensity to higher.
- Examples of moving a client from **Tier Two to Tier Three** include:
  - a. The client's Patient Activation Measure (PAM) score has stabilized over the past four month period with optimal level of activation and HAP goals have been achieved.
  - b. The client's PRISM risk score is under 1.0 for eight months and the client's PAM Level is at least a three.
  - c. A client has met their goals and is actively sustaining self-management activities.
  - d. The client has no new HAP goals to set or current issues to achieve requiring a higher level of coordination, and has achieved and demonstrated self-management skills. Goals may be modified or new goals added in collaboration by the client with the care coordinator.
  - e. The client requests a lower level of care coordination.
  - f. The client was not available during the month and the care coordinator provided follow-up care coordination with service providers or community resources.
- Examples of moving a client from **Tier Three to Tier Two** include:
  - a. An adverse health condition or new diagnosis resulting in increased emergency department use, hospital admissions, readmissions, escalation or exacerbation of a behavioral health or social concern.
  - b. The client expresses a desire to set a new HAP goal.
  - c. Environmental or psychosocial changes trigger a need for more intensive Health Home services.
  - d. Life events trigger a need for higher Health Homes Services.

## **Unsuccessful Initial Outreach and Engagement:**

- Some clients may not be successfully reached or engaged in Health Home services despite multiple attempts to contact them in person, by phone, by mail, or through collateral contacts. In these situations a Tier One claim for the engagement attempts cannot be submitted. The Care Coordinator must consult with their organization for direction regarding policy and procedure for engagement attempts and documentation of failed attempts to reach a client.
- When a client is not actively participating in the Health Home Program a claim cannot be submitted to reflect the outreach attempts only.

REMEMBER: A qualifying Health Home service must be provided each month in order to submit a claim for Tier Two or Tier Three payment.